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**Article Title:** 'Falls in the Residential Independent Care Sector – Ambiguity in Guidelines and Policies for Healthcare Assistants'

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**Abstract:** The need for Healthcare Assistants (HCAs) to have clear policies and guidelines in relation to when falls occur in domiciliary care settings is paramount. If first line responses are to be both appropriately tailored to patient need and discernment is to be used in determining the necessity for intervention by emergency care workers such as paramedics then standardised frameworks and policies ought to be apparent across care sectors. Our work focused on the first line response to patient falls operational in the independent care sector in a specific geographical region of North East England. This article aims to provide an insight into what our original findings revealed and how they might be used as a source of reflection for HCAs working in the residential independent care sector. Using a basic questionnaire, we surveyed 24 of the 32 independent care sector homes (75%) in South Tyneside to establish how policies and guidelines in these organisations were understood by staff. Our findings highlight a diverse array of responses to falls in care home settings. Whilst 96% of homes claimed to have a specific policy on falls, only 80% of them included an assessment of possible injury or harm to residents and 13% included no direct guidance for care staff in instances where residents fell and were still on the floor. Even in instances where policies did include direct guidance, there was great variation in available information for staff, especially between domiciliary and care home settings. Most commonly staff were advised to call an emergency ambulance, even in the absence of injury, if patients were found on the floor. HCAs are working in contexts where there is apparently a high degree of ambiguity around the assessment of injuries sustained as a consequence of falls; particularly where potentially non-visible injuries occur, which are not immediately recognisable or symptomatic. There was also overlap between accident and falls

policies, which added a further level of ambiguity to the most appropriate and immediate actions for HCAs.

**Keywords:** Falls; Independent Care Sector; Residential; Domiciliary; Emergency Ambulance Services; Healthcare Assistants (HCAs)

### Key Messages for Healthcare Assistants

<b>First Line Response in the Event of a Fall</b>	
<b>Key Points for Reflection on HCA Practice</b>	
<b>Induction Training</b>	<ul style="list-style-type: none"> <li>• Did your induction training cover falls?</li> <li>• Can you differentiate between your falls policy and your accident policy or is there an overlap between the two?</li> <li>• What did you sign as part of the record that you have received falls training?</li> <li>• What are the implications of signing this record for you and for the people you care for?</li> <li>• How often do you need to undertake falls training?</li> </ul>
<b>Emergency Response</b>	<ul style="list-style-type: none"> <li>• How would you decide when to call an ambulance?</li> <li>• Do you feel equipped to deal with a person in your care if they have suffered a fall? If not, can you seek additional support and training from your employer?</li> <li>• Do you feel equipped to provide emergency first aid? If not, can you seek additional support and training from your employer?</li> </ul>
<b>Individualising Support and Care</b>	<ul style="list-style-type: none"> <li>• Do you feel equipped to provide reassurance and support for someone who has fallen and might need to await care from emergency services? If not, can you seek additional support and training from your employer?</li> </ul>
<b>Recognition of Scope of Practice</b>	<ul style="list-style-type: none"> <li>• Are you aware of your own scope of practice and the limits within which you must work as an HCA? Have you taken time to reflect on this scope of practice so that your decision making is clear in an instance of a patient falling?</li> </ul>
<b>Resilience and Coping Strategies</b>	<ul style="list-style-type: none"> <li>• Dealing with the emergency incidence of a fall in everyday practice can be an upsetting and stressful event for anyone with a responsibility for caring for others. Have you thought about your own resilience and coping strategies? If not, can you seek additional support and training from your employer?</li> </ul>

### Introduction

There is much variation in how the independent care sector responds to when patients fall, in particular how it is decided whether an emergency ambulance needs to be requested (Jennings and Matheson-Monnet, 2017). It has also been discovered that there are trends in the likelihood of ambulances being called, which can be linked to the background location and personal circumstances of those who have fallen. For example in areas where there is a low socioeconomic

climate, much chronic disease and in instances where healthcare accessibility is thought of as being low, then the likelihood of an ambulance being called is statistically much higher (Hudon, Sanche and Haggerty, 2016; Scapinello, 2016). As HCAs are often in situations where patients could potentially fall, then being able to reflect on an appropriate response that is commensurate with the local policies and guidelines of an employing organisation is important for HCAs in their everyday practice and in recognition of the contribution they make to society.

This paper provides an insight into some research we undertook into the operationalisation of policy in response to falls in South Tyneside North East England. Overall it reveals that there is a lack of discernment in relation to the appropriateness of calling emergency ambulances in the independent care sector. In some instances, this practice forms an integral part of independent care sector policy around what HCA staff are to do in the instance of patients falling to the ground and being unable to get up again. Often the reason for requesting emergency ambulance services is attributed to instances of minor injury, which could potentially be best treated in the context of basic first aid in the home, in primary care settings or even simply helping patients to manoeuvre into a position of being able to remobilise themselves. Whatever the reason, there is a lack of parity between what staff are required to do and much ambiguity surrounding exactly where responsibility for vulnerable people actually lies.

### **The Need to Raise Awareness**

Raising awareness of the implications of the unnecessary use of emergency services is pivotal if the wasting of resources for emergency care is to be prevented. If organisations are to realise the fiscal expense and potential human cost of wasted time for paramedics in practice then educating care staff from all levels of the organisational hierarchy must become a priority. We use some descriptive statistics to illustrate this issue so that an insight can be provided into the instances where emergency services are most likely to be called.

### **The Study**

The aim of our research was to provide an illustration of the first line response to patient falls that is currently operational in the independent care sector in a specific geographical region of North East England, UK. This took place in nursing, domiciliary and residential contexts. We felt this was representative of the scope and practice of organisations in the independent care sector in this particular region of the UK. We used a questionnaire to survey 24 of the 32 organisations in the region, the findings of which were made up of 8 returns from nursing organisations, 3 from domiciliary care settings and 13 from residential care settings. The nine areas of focus are outlined below:

#### **1. What is the Organisation's Current Policy in Relation to Falls?**

96% (23) of the homes who participated in the study had a policy on falls, whereas 4% reported they had no policy at all in relation the management of falls.

#### **2. How is Staff Awareness of Falls Policy and Appropriate Action in the Event of a Fall Achieved?**

87% of the homes who reported having a policy, said that their policy had specific guidance for staff on what to do if a resident fell and was on the floor, whilst the remaining 13% who had a policy on falls had no direct guidance for their staff. As an adjunct to this question, the 87% organisations of organisations with a positive response to this question were asked to provide details of the information that staff were given. Their responses could be divided into clear areas of focus:

- a) Induction training
- b) Onus on staff accountability
- c) Ongoing In house training via staff development
- d) Direct and adjunct association with organisational lifting and handling policies
- e) Recording and documenting falls correctly and auditing their occurrence.

**3. What happens when a resident falls and cannot get up unaided? Are there policy requirements?**

The commonest response to this was that staff were required to ring for an ambulance and in these organisations, there was an institutional policy that staff were not to move clients, if they had fallen to the floor. A minority of organisations reported that their staff were expected to use hoists to move patients from the floor. In instances where patients lived in their own homes there was no policy and decision making was left to the discernment of the carer, regardless who that might be or the circumstances that the patient had been found in. Some organisations reported having an individualised care plan for each patient and that carers had to use this in instances where patients fell. Qualified nursing staff were used to check for head injuries and broken bones in some organisations and some reported only causing an ambulance if there were signs of 'visual injuries'. In instances where it was suspected that a patient had a spinal or hip injury it was a policy that an ambulance must be called in one organisation. Another organisation reported that there was nothing in the policy about what to do in the instance that a client had a fall. The responses from each responding organisation are listed below:

*'After someone has fallen it is suggested that a Post Falls Assessment is carried out, this will then be specific to the individual within the home.'* (Organisation 1)

*'Ring for wardens/ambulance.'* (Organisation 2)

*'No policy in place due to clients living in their own homes.'* (Organisation 3)

*'if appropriate use hoist.'* (Organisation 4)

*'They phone an ambulance and make no attempt at all to move the service user.'* (Organisation 5)

*'Staff follow each residents moving and handling document this is in each residents care plan.'* (Organisation 6)

*'All customers are assessed by our mobility co, we must follow the correct procedure in plan. Provided there are no injuries.'* (Organisation 7)

*'Call for medical help.'* (Organisation 8)

*'Always hoisted. RGN to check for immediate signs of injury, accident form, report, 12hr, 24hr and 36 hr check. head injuries 111 or 999.'* (Organisation 9)

*'Registered nurse completes a full body assessment to assess for any broken bones.'* (Organisation 10)

*'To check for any visual injuries to contact emergency services if resident is complaining of any pain or unable to get up of the floor and to look at the capacity of the resident if they're able to state in pain.'* (Organisation 11)

*'Not in policy.'* (Organisation 12)

*'Carry out a full body check to identify for injuries, if no injuries are identified and the person is unable to say we would contact healthcare professional for advice. And carry out observation for any side effects or more discomfort.'* (Organisation 13)

*'Use hoist.'* (Organisation 14)

*'Would contact healthcare professional, if unable to get up, unaided, if fall was not witnessed, and no visible injuries identified and person was unable to say how they were on the floor.'* (Organisation 15)

*'We have an accident policy and the staff have falls training, however, the policy does not state what to do in the event service user falling. The reporting of accident policy has guidelines on how to manage and report injury and accidents.'* (Organisation 16)

*'Check for injuries. If concerned contact emergency services and if no injuries support resident or use hoist depending on their needs.'* (Organisation 17)

*'Hoist.'* (Organisation 18)

*'Call 999.'* (Organisation 19)

*'To assess and utilise the appropriate equipment if injuries are not evident.'* (Organisation 20)

*'If injuries are evident we are to make them comfortable and await emergency services.'*  
(Organisation 21)

*'Check the resident for any injuries, and they are suspecting any fracture hip or spine - contact emergency ambulance services for further support.'* (Organisation 22)

*Press emergency buzzer for more senior staff to attend and assess situation.* (Organisation 23)

*All falls by Service Users no matter how trivial are immediately recorded in Care. Plan daily records also in Accident book, Nurses inform falls team for assessment.* (Organisation 24)

**4. Does your organisation have a policy inclusion of the assessment of injuries or harm sustained as a consequence of falling?**

79% of the organisations we surveyed reported that they had an inclusion in their falls assessment policy that clients ought to be assessed in relation to sustained injury or harm as a consequence of a fall. The remaining 21% of organisations had no specific recommendations in their falls policy of how staff ought to assess the condition of the client who had fallen.

**5. Whether clear guidelines exist in those organisations who stated they had a policy inclusion of assessment of sustained injury or harm to residents**

As with the previous question, this part of the survey revealed that 79% of organisations reported having an inclusion in their falls policy of assessments that clients ought to be subject to assessment to ascertain whether they had sustained injury or harm as a consequence of a fall. 21% of organisations had no specific recommendations in their falls policy of how staff ought to assess the condition of the client who had fallen.

**6. Whether clear guidelines, which are aligned to the policy, exist in those organisations who stated they had a policy inclusion of assessment of sustained injury or harm to residents in the event of them having a fall.**

79% of those organisations who reported having an inclusive policy of assessment of sustained injury or harm to residents responded that clear guidelines were available to follow in instances of there being no harm or injury apparent, and 21% reported clear guidelines for instances where there was concern that harm or injury had occurred.

#### **7. Under which circumstances an ambulance would be called?**

There were 23 organisations who responded to this survey question. 1 organisation omitted to enter a response. Specific responses are detailed below:

*'If the individual is unable to mobilise normally, if they are expressing pain, if the individual is unconscious.'* (Organisation 1)

*'If the service users in hurt or in pain'* (Organisation 2)

*'Due to each client being in their own home, we would contact an ambulance if they were to sustain an injury. Otherwise we would contact GP/DN for advice.'* (Organisation 3)

*'Suspicion of serious injury.'* (Organisation 4)

*'With falls we ring ambulance immediately'* (Organisation 5)

*'If the resident has a suspected injury fracture or bleeding, nasty bump'* (Organisation 6)

*'If head injury or suspected fracture.'* (Organisation 7)

*'Head injury, fractures, resident shows clear signs of severe pain in limbs.'* (Organisation 8)

*'From the assessment if there were any signs of broken bones or lacerations that won't stop bleeding.'* (Organisation 9)

*'If service user has sustained injury if a service users is unable to move limbs, head injury, bleeding and if a resident is unable to state in pain due to capacity.'* (Organisation 10)

*'Head injury, obvious injury.'* (Organisation 11)

*'When injuries are identified or any distress.'* (Organisation 12)

*'Serious Injury - Fractures – Cuts.'* (Organisation 14)

*'If person was unable to get up themselves, if person has any identified injuries or signs of any discomfort or pain.'* (Organisation 15)

*'If the person was none responsive, hurt or injured and was unable to get up.'* (Organisation 16)

*'If the client could not move, depending on the type of injury. Assess the situation at the time.'* (Organisation 17)

*'Suspected /actual injury, any loss of consciousness, and evidence of sudden onset illness.'* (Organisation 18)

*'Head Injury suspected fracture.'* (Organisation 19)

*'If injury was evident or head injury suspected.'* (Organisation 20)

*'any suspected fracture or head injury, heavy bleeding , large soft tissue or tendon injuries.'* (Organisation 21)

*'Head Injuries, Broken bones, Unconsciousness if the injury is causing pain or discomfort in any limbs ,back or hip area or a severe head wound or blow to the head is present/suspected, then an ambulance must be called. Also, for any cut that is more than superficial to any area. If the service user has abnormal bruising to or is on blood thinning medication.'* (Organisation 22)

'Yes.' (Organisation 23)

**8. Whether there is any guidance to follow for care staff if a resident is on the floor, and an ambulance has been called but is delayed in responding due to high levels of activity?**

50% of organisations responded affirming the availability of guidance for care staff if a resident is on the floor, and an ambulance has been called but is delayed in responding due to high levels of activity. The remaining 50% of respondents said they had no availability of guidance in these circumstances.

**9. Whether staff had accessed any falls training?**

Staff reported having accessed staff development sessions, which was clearly divided into 'in house training' and e-learning packages.

**Discussion**

The findings of our study have important implications for HCAs employed in the independent care sector. It can be concluded that clear differentiation between policies and guidelines and their local implementation in practice ought to be made. Equally importantly it raises the issue of the need for HCAs to seek specific support and guidance from managers, in instances where specific training has not yet been provided or in instances where there is any degree of ambiguity in practice. Our small scale study, of a small geographical region of north east England, examined policies and guidelines for falls in the independent care sector homes from 24 independent sector settings. Findings highlight the relatively disparate responses to falls in the care home settings; despite 96% of homes having a policy on falls, only 80% of these included an assessment of possible injury or harm to residents and 13% included no direct guidance for their care staff in instances where residents fall and are on the floor. For policies that did include direct guidance, there was a great disparity in available information, especially between domiciliary and residential care home settings. The most common recommended action, was to call emergency services in order to move patients, even in the absence of physical injury. Findings were consistent with those outlined in the extant literature, which also highlighted the inappropriate use of Accident and Emergency services (Chalk, Black and Pitt, 2016). Whilst our research indicated the common use of ambulances as a common policy, the literature indicates that patterns may also exist where there is a correlation between minimal staffing in the independent care sector and inappropriate ambulance use, for example during night shifts where often skeleton staffing, including the regular use of HCAs, is used to cover the care of significant numbers of patients (Bruni, Mammi and Ugolini, 2016). In certain instances there may be a definite overlap between falls and accident policies, which necessitates even more discernment by HCAs as to how to classify an incident that has occurred in residential care settings.

From a training perspective, it is clear that there ought to be a degree of standardisation in training surrounding falls for all HCAs if patients are to receive optimal and consistent care in everyday health and social care practice. There is currently minimal evidence to suggest a robust and transferrable training and development programme for all independent care sector workers in the context of our research, despite several being established in recent years (McKenzie et al, 2017; Richardson et al, 2015). Almost all which do exist focus on legalism, with staff signing to say they



have gained an insight into falls and that they are aware of how to deal with them in practice. (Goldsack et al, 2015; Singh, 2015).

## Conclusion

Our research reveals a lack of available information for those HCA staff working in the context of domiciliary care, where policy implementation is not always adopted. Perhaps of greatest concern, is that 21% of organisations in our research reported having no specific recommendations in their falls policy of how HCA staff ought to assess the condition of the client who has fallen.

There is a clear need for the provision of definitive training of HCA staff in emergency first aid. The re-mobilisation of clients and most significantly the circumstances in which it is wholly appropriate for them to request emergency care provision from paramedic practice.

It illuminates the potential for interventions with HCA education and training packages and highlights the evident need for representation by the paramedic profession at committees where optimal responses to care in the independent sector are being formalised and sanctioned for operationalisation in HCA practice.

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